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June 6, 2005

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

Jonathan E. Fielding, M.D., M.P.H.
Director of Public Health and Health Officer

SUBJECT: **NEEDLE EXCHANGE CERTIFICATON PROGRAM**

On August 29, 2000 the Los Angeles County Board of Supervisors (Board) instructed the Department of Health Services (DHS) to develop a plan to certify needle exchange programs in Los Angeles County on a replacement basis. Although the implementation plan was developed, as well as program guidelines, a detailed policy and procedure manual, a request for applications, and agreement to be used for needle exchange programs approved for certification, needle exchange certification has not yet been implemented by the Department.

This is to provide additional information regarding the activities undertaken by DHS to implement a needle exchange certification process in Los Angeles County in response to issues raised at the May 17, 2005 Board meeting. The attached report summarizes the development and initial attempts to implement the certification process as well as recommendations for implementation of certification in the future.

The Department recommends re-initiation of the needle exchange certification program consistent with public health best practices, as an important component in increasing access to sterile injection equipment to reduce transmission of HIV, Hepatitis C and other blood borne pathogens.

If you have any questions or need additional information please let either of us know.

TG:JEF:al
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Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

Los Angeles County Needle Exchange Program Certification: Process, Status and Recommendations June 2005

Introduction

This document provides a summary of the activities related to the development and implementation of a Los Angeles County needle exchange certification process and recommendations regarding future implementation.

Section I describes the activities undertaken by the Los Angeles County Department of Health Services, Public Health from September 2000 through August 2004 in an effort to implement certified needle exchange programs in Los Angeles County as instructed by the Board of Supervisors (Board). Full implementation of needle exchange certification was postponed in August 2004 as will be discussed in detail below. Section II of the report provides Public Health's recommendations regarding how the needle exchange certification process might be successfully implemented in the future.

SECTION I. History and Status of Needle Exchange Program Certification

Background

Needle exchange programs (NEPs) began in the 1980s largely as a public health response to the HIV epidemic and, later, to many preventable cases of Hepatitis B and C (HCV). In 2004, approximately 15 percent of Los Angeles County reported AIDS cases were in injection-associated categories, i.e. male and female injection drug users (IDUs), and men who have sex with men and inject drugs (MSM IDUs). In 2002, there were 9,691 chronic HCV cases reported in Los Angeles County.[1] NEPs, by providing people with access to clean syringes, help prevent further transmission of HIV and other blood-borne pathogens.[2,3] In addition, NEPs serve as an important venue for providing injection drug users with referrals to medical and social services, including access to drug treatment.[4, 5]

When DHS began exploring the certifying needle exchange programs in Los Angeles County, California law prohibited the furnishing, possession or use of hypodermic needles without a prescription. Assembly Bill 136 (AB 136), Clean Needle and Syringe Exchange Projects was approved by Governor Gray Davis on October 7, 1999. It amended Section 11364.7 of the California Health and Safety Code to exempt from criminal prosecution public entities and their agents and employees who distribute hypodermic needles or syringes to participants in clean needle and needle exchange projects that are authorized by the public entity pursuant to a declaration of local emergency due to a critical public health crisis.

On August 29, 2000, the Board instructed the Department of Health Services (DHS) to develop a plan to certify needle exchange programs in Los Angeles County on a replacement basis (Appendix One). In exchange for following the County's needle exchange guidelines, certified agencies would receive protection from criminal prosecution, as indicated by AB136. This action was taken in recognition of the public health crisis related to the transmission of HIV and hepatitis due to needle sharing among injection drug users and the considerable literature indicating the efficacy of needle exchange as an effective risk reduction intervention.[6,7]

DHS, in conjunction with key stakeholders, developed a process for certifying NEPs in Los Angeles County and prepared an implementation plan for doing so (Appendix Two).

NEP Plan Development

The Needle Exchange Implementation Work Group was convened in September 2000 to develop a plan to certify needle exchange programs in Los Angeles County. The work group included staff from several DHS Public Health programs and representatives from the Sheriff's Department, representatives of the HIV Health Services and Narcotics and Dangerous Drug Commissions, the Second District Coalition and HIV Prevention Planning Committee. The Los Angeles City AIDS Coordinator and representatives from the Los Angeles Needle Exchange Consortia, RAND and the Long Beach Health Department provided additional input and expertise. The resulting plan emphasized collaboration between public health, law enforcement and the community in promoting the health and safety of the population of Los Angeles County by supporting programs designed to prevent HIV/AIDS and other injection-related infectious diseases and drug dependency.

In developing the Needle Exchange Certification Plan (plan), the work group reviewed existing needle exchange programs in Los Angeles County and other jurisdictions, data related to the potential demand for needle exchange services in Los Angeles County and conducted a focus group with current needle exchange providers to assess gaps in services for injecting drug users in the County. Public health literature regarding effective needle exchange programs was reviewed to ensure that the plan developed would follow best practices as closely as possible.

Overview of the Implementation Plan

The plan outlined a three-phase implementation process for certifying needle exchange programs in Los Angeles County. During Phase I, the County would certify existing needle exchange programs provided they agreed to follow the County's needle exchange guidelines, which specify that needles would be available to clients enrolled in programs on a one-to-one replacement basis. At the time the plan was developed, seven agencies conducted needle exchange in the City of Los Angeles, five as a part of a City funded HIV risk and harm reduction consortium. The plan specified that certified programs would work with resource specialists from the County Alcohol and Drug Program Administration's Community Assessment Services Centers to ensure that needle exchange clients who request placement in drug treatment programs and other services would be placed as quickly as possible to ensure the best possible outcomes. During Phase II, needs assessments would be conducted to identify gaps in needle exchange services. Needle exchange services would continue at sites certified in Phase I. Contingent of the availability of funding, a Request for Proposals would be issued to expand services into additional high-need areas. In Phase III, agencies submitting successful proposals would begin needle exchange services.

The plan specified that once the needle exchange implementation plan was submitted to the Board Phase I of the implementation process would begin. For those existing providers willing to adhere in exchange for avoiding criminal liability, programs would be monitored by Public Health to ensure compliance with County guidelines. Data collected at the sites would be reviewed to ensure that needle exchange clients were being referred into drug treatment and other services and to help determine where new exchange sites were needed. Zip code of residence of needle exchange clients and demand for services at existing needle exchanges would provide information about the need for additional exchange sites in other areas of the County. The initial implementation plan was completed in April 2001.

Preparation of Other Documents

In addition to the implementation plan a more detailed Policy and Procedures Manual was developed to provide operational guidance on operation of certified needle exchange sites based on guidelines developed by the Workgroup in conjunction with the Narcotics and Dangerous Drug Commission. An

initial Policies and Procedures manual was completed in June 2002. A Request for Applications (RFA) and a Certified Needle Exchange Program Agreement to be signed by the agencies successful in the application process also were prepared. All of these documents were revised extensively over the next eighteen months. Most of the documents needed for the process were completed in May 2004. Factors impacting the preparation of these documents included: (a) lack of staffing (no full time staff were available to be assigned to this complex project); (b) the need for an inclusive process of development requiring meetings with existing stakeholders and commission representatives and time for stakeholders to review new drafts; (3) the need for consistency in the documents (e.g., a change in the implementation plan or protocol required similar changes in the Agreement, Request for Applications and related forms, and then required review); and the need for review and approval of documents by County Counsel and Contracts and Grants. Following a lengthy process of obtaining stakeholder input and consulting with County Counsel, Public Health was prepared to issue the Request for Applications to existing needle exchange programs in the late spring of 2004.

Concurrent Pending Legislation

At the same time two pieces of legislation were under consideration that would potentially impact access to syringes in Los Angeles County.

- Assembly Bill 2871 (Berg), Clean needle and syringe exchange: AIDS and hepatitis, would have authorized cities, counties, or cities and counties to have a clean needle and syringe exchange program that, in consultation with the State Department of Health Services, authorizes the exchange of clean hypodermic needles and syringes as part of a network of comprehensive services. This would have potentially expanded options for other cities to develop and implement needle exchange programs in the absence of a County program. AB 2871 was vetoed September 2004.

- Senate Bill 1159 (Vasconcellos), legislation to permit purchasing of hypodermic needles and syringes, was signed into law in September 2004. The legislation, which allows pharmacists to sell 10 or fewer hypodermic needles to persons 18 years or older without a prescription as part of a demonstration project entitled Disease Prevention Demonstration Project (DPDP), remains in effect until December 31, 2010. SB1159, subject to authorization by a city or county, is intended to prevent the spread of HIV, hepatitis and other blood borne diseases among IDUs, their partners and their children by allowing greater access to needles and syringes. Local health departments are required to register pharmacies that wish to participate, to maintain a list of registered pharmacies and make available to pharmacies written information to be distributed to customers purchasing syringes on drug treatment, testing and treatment for HIV and HCV, and how to safely dispose of sharps waste. DHS is required to implement registration of pharmacies for cities authorizing the project in Los Angeles County. Both the Cities of Los Angeles and West Hollywood have authorized the DPDP project and are awaiting implementation by DHS.

Barriers to Implementing Needle Exchange Certification

When the needle exchange certification workgroup convened by Public Health began developing the NEP certification plan in 2000, it appeared that funding might be available to implement the certification program. Tobacco Settlement funds had been considered as a possible source of funding. The workgroup felt that during Phase I a portion of these funds would best be used to purchase syringes for distribution at certified sites with the remainder going toward paying for safe disposal of used needles and syringes. These funding needs were high on the priority list for existing needle exchange programs as many of their existing funders prohibited the purchase of syringes. After discussion with County Counsel in May 2002 it was determined that County funding for syringes or use of syringe disposal facilities at County health

facilities could potentially expose the county to increased liability. The option of providing funding to sites for syringes and disposal was not pursued further.

At the same time, DHS planned to place certain restrictions on NEPs that wished to be certified, notably: 1) exchanges must take place on a "replacement basis" interpreted as a one-for-one only, and 2) only persons 18 years of age or older would be allowed to use certified sites. After consultation with County Counsel it was determined that emancipated minors would also be allowed to receive needle exchange services. These restrictions, although inconsistent with public health best practice recommendations to provide a sterile syringe for each injection[8], were initially accepted by some of the existing needle exchange programs. However to some agencies, the value of certification was greatly diminished as it appeared that the only benefit of certification was the offer of limited protection from liability for paid and volunteers needle exchange staff.

Decision to Postpone Implementation

When it came time to discuss releasing a Request for Proposals for NEP certification, the City of Los Angeles voiced concerns on behalf of the agencies it funds to operate NEPs, suggesting that discussion with these programs indicated that they would opt out of the process due to the imposition of stringent restrictions without new funding or other incentives. These concerns are discussed in correspondence from the City of Los Angeles (Attachment Three). The entire implementation process was put on hold in August 2004 both because of provider lack of interest and the likelihood that Governor Schwarzenegger would sign SB1159 allowing pharmacy syringe sales, thereby increasing access to sterile needles and syringes through another venue. DHS hoped that the syringe sales program would be a supplement to needle exchange and help improve access to syringes to reduce HIV and Hepatitis C risk.

SECTION II. Recommendations for Proceeding with a NEP Certification Process

Needle exchange programs began operating in the United States in the late 1980s as a public health response to the HIV epidemic. A preponderance of the literature has shown that needle exchange programs have been effective in reducing transmission risks among IDUs.[9,10] In addition to reducing transmission, these programs are also cost effective. A recent analysis indicated that up to 12,350 persons would become infected with HIV in the United States for each year that IDUs do not have increased access to needle exchange programs, leading to an estimated $1.3 billion in future medical costs for these persons.[11] Further, according to recent research, an estimated 7 percent of inpatient admissions to San Francisco General Hospital were for soft tissue infections related to injection drug use, including abscesses, resulting in steep costs for hospitalization as well as harm to the patient.[12] Such infections could be reduced significantly if IDUs had better access to medical care, which needle exchange can facilitate through wrap-around services.

Estimated Need for Needle Exchange Services in Los Angeles County

It is estimated that there are between 120,000 and 190,000 injection drug users in Los Angeles County.[13] Several sources of information regarding IDUs were examined in order to estimate potential demand for needle exchange services including information from County-funded drug treatment programs, AIDS case data and current needle exchange programs. Based on previous data we estimate that there are at least 130,000 IDUs not currently in drug treatment or accessing needle exchange that are at risk of acquiring HIV or Hepatitis C from used syringes.[14] Studies with Los Angeles County IDUs indicate that 45 percent

share injection equipment.[15] Using this proportion, an estimated 69,000 IDUs use shared injection equipment countywide.[a]

DHS recognizes needle exchange, when combined with a comprehensive referral program, is an effective HIV and Hepatitis C risk reduction intervention. DHS strongly recommends the re-initiation of the needle exchange certification in a manner that will facilitate participation by existing needle exchange programs while maintaining practices associated with program effectiveness.

Options for Implementation

Currently two options exist for implementation of certified needle exchange in Los Angeles County:

1. Revise the existing implementation plan and related documents to simplify the certification process, remove requirement that returned syringes be counted at the needle exchange site to confirm the one-to-one replacement of syringes and include a section on emancipated minors. Then issue a limited RFA (restricted to current needle exchange programs) and proceed with certification under the Health Officer.

2. Develop a mechanism to provide funding to needle exchange programs to help defray the cost of syringes and release a request for proposals to certify the needle exchange programs using the revised guidelines and application process described above.

DHS Recommendation

DHS recommends initially proceeding with Option 1 as described below. This option addresses some of the barriers initially encountered during the initial implementation process while allowing for certification of programs consistent with best practices for needle exchange programs.

Actions to Reduce Barriers to Implementation:

- ***Simplify the application process.*** The complex certification process will be simplified reducing disruption of existing NEP services during the application process.

- ***Address concerns regarding one-to-one exchange.*** Relaxing the strict one-to-one replacement policy will mean that programs no longer must sort, cap and count each syringe, thereby reducing risk to NEP workers and program participants.

- ***Address concerns regarding denying those less than 18 years of age access to services.*** Clarifying the inclusion of emancipated minors may facilitate application by needle exchange programs that interact with IDUs under the age of 18.

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[a] *The 62,962 estimate may over- or underestimate the actual numbers of IDUs that share needles in Los Angeles County. Underestimation may result from: (1) underestimating the proportion of individuals that share needles; and (2) assuming those in treatment programs and in needle exchange programs no longer share needles. Over-estimation may result from: (1) underestimating the number of people in treatment (probable because data were not available for privately-funded treatment programs); (2) over-estimating the proportion of IDUs that share needles; (3) assuming that needle exchange program participants only exchange for themselves, rather than for other IDUs; and (4) underestimating the number of IDUs that use needle exchange.*

- ***Simplify guidelines regarding the conduct of needle exchange.*** This includes revision of the Policies and Procedures manual to provide more flexibility in the conduct of needle exchange by programs (eliminating requirements for single file lines, simplifying requirements regarding referrals, expanding options for disposal, simplifying data collection requirements. etc.).

- ***Address concerns regarding syringe disposal.*** The previous process required needle exchange programs to submit paperwork demonstrating that they were registered with the California Department of Health Services as medical waste generators. SB 1362 allows for the disposal of syringes at household hazardous waste sites. SB 1159 allows NEPs and others to transport (in appropriate containers) used needles and syringes to disposal sites, facilitating safe disposal. Including reference to this change in the implementation plan and related documents may help address these concerns.

Recommended Best Practices

Needle exchange has become an important public health service because it facilitates IDUs' access to sterile needles. In addition, it provides linkages to drug treatment and other services for IDUs and can thus help move IDUs through a continuum of behavior change from injecting drugs to becoming drug-free. This section will discuss recommended best practices for inclusion in Los Angeles County's NEP certification guidelines.

- ***DHS proposes including in the needle exchange guidelines the option of providing an initial harm reduction kit in emergencies for those users that may come to an exchange site without a syringe to exchange.*** IDUs share needles because of lack of access to sterile needles and the fear of arrest for carrying needles.[16, 17, 18] In Los Angeles, both City and privately funded needle exchange programs provide clients with harm reduction tools such as bleach for cleaning needles, alcohol swabs and antibiotic cream for preventing abscesses and other infections, and condoms to prevent spread of STDs and HIV. IDUs must have sufficient syringes to prevent sharing. Exchange programs should be able to take into account loss, confiscation and theft of syringes in their exchange protocols.

- ***Reduce emphasis on age, to allow certified sites to provide exchange services to emancipated youth and to provide referral and other risk reduction services to non-emancipated youth.*** Research indicates that the availability of needle exchange in a community does not encourage non-users to begin injecting drugs, nor does it increase drug use among IDUs.[19] Minimum client age limits are relatively rare at needle exchanges in the United States.[3] Many IDUs under age 21 using needle exchange services are "runaway" or "throwaway" youth living on the streets. These youth are often emancipated. Because patterns of needle sharing are similar regardless of age, it is important to provide needle exchange services to these youth to reduce the risk of HIV and hepatitis transmission.

- ***Allow flexibility in needle exchange venues.*** While there are many types of sites, most are either street-based or based in agencies that provide related services for IDUs. We recommend that all venues be allowed for verification including street-based, store-front, agency and mobile van sites. In Los Angeles, the majority of current exchanges are street-based, i.e. they operate out of the backs of vans or on card tables set up on the streets in fixed locations on specific days and times each week. All of these sites, provided they meet the revised certification criteria will be eligible for certification

- ***Allow sites flexibility in providing access to other wrap-around services.*** As a part of the certification process, applicant needle exchange programs will be asked to provide information about the agencies that will provide drug treatment and other wrap-around services for needle exchange clients. Needle exchange also can provide referrals to other types of services IDUs do not usually

seek, such as medical care. This is particularly important in light of evidence indicating the severity of illness and high costs incurred when IDUs do not access these services when the need first arises.[20]

Proposed Implementation Process

- ***Reconvene the needle exchange implementation workgroup and include law enforcement representatives to facilitate implementation of needle exchange in street-based sites.*** Historically public health and law enforcement have adopted different approaches in dealing with injecting drug users. While public health officials advocate providing IDUs with sterile needles as a risk reduction activity, law enforcement officials are charged with enforcing paraphernalia laws. In order for NEPs to provide the most effective harm reduction services communication and cooperation are required between public health and law enforcement communities.[21] In jurisdictions that prohibit the possession of injection equipment without a prescription, IDUs sometimes are arrested for carrying syringes. Although SB 1159 allows for the possession of up to ten clean syringes obtained from an authorized source (e.g., pharmacies, needle exchange programs), many IDUs are unaware of the law and are afraid to carry syringes for fear of arrest, leading to increased risk through needle sharing and improper disposal. Following a partial repeal of paraphernalia laws in Connecticut, syringe sharing decreased.[22] Further, the needle-stick injury rates among Hartford police officers also were lower after the new laws.[23] Changes in California's drug paraphernalia law due to SB 1159 may have a similar impact. Informing law enforcement about this change and its relation to needle exchange will be facilitated by law enforcement involvement in the workgroup.

- ***Work with Alcohol and Drug Program Administration to facilitate access to drug treatment services for NEP clients.*** Needle exchange programs can serve as a conduit into treatment for IDUs.[6, 24, 25] however, it is important that entry into treatment take place quickly once an IDU requests a referral. There is an increased failure rate associated with delayed entrance into drug treatment among IDUs utilizing needle exchange services. According to one study in New Haven,[5] IDUs who had to wait more than three weeks to be placed in treatment were more likely to fail to complete that treatment. Los Angeles needle exchange providers stressed the importance to their clientele of assuring that they are able to access drug treatment as soon as possible.

Proceeding with Needle Exchange Certification: Next Steps

DHS recommends the following specific steps to proceed with implementation of needle exchange program certification:

- Reconvene needle exchange certification workgroup and discuss needed changes in the policies and procedure manual and implementation plan.
- Revise implementation plan and related certification documents.
- Issue Request for Applications to existing needle exchange programs.
- Certify needle exchange programs meeting certification requirements.
- Monitor certified needle exchange programs for compliance with guidelines.
- Conduct a needs assessment to identify need for additional needle exchange services and to assess the impact of SB 1159 implementation on demand for needle exchange.

- Work with needle exchange workgroup to identify other sources of funding for expansion of needle exchange in Los Angeles County.

Cost of the Certification Process

Provision of certification will require at least one full-time equivalent (FTE) staff person to serve as the certification program's coordinator. Public Health plans to use existing resources to provide staff support for the project. DHS' Alcohol and Drug Program Administration has committed to providing SPA-level linkage and liaison to drug treatment programs for needle exchange programs through their Community Assessment Service Centers. This will provide the part-time support of eight FTEs to link with needle exchange programs.

We have estimated that one part-time contract program auditor will be needed to conduct site visits and review program data and documentation as a part of the certification program. In addition, one part-time administrative staff person will be needed to provide administrative support and coordination of certification activities. Preliminary estimated costs associated with certifying the existing needle exchange programs to allow them to expand to unincorporated areas of the County are estimated at $180,000 for one full-time analyst to serve as the certification program coordinator, a 50% contract program auditor to assist in program monitoring, and a 50% staff assistant to assist with certification program implementation and to staff the on-going workgroup.

Unresolved Issues

Although DHS has recommended proceeding with a simplified process of certification for existing needle exchange programs, it is clear that other issues remain.

Unmet Need. The existing needle exchange programs only serve a small proportion of the estimated 130,000 IDUs at risk in Los Angeles County. Although implementation of pharmacy-based syringe sales in authorizing cities (currently Los Angeles and West Hollywood) will provide additional access to sterile syringes it is unlikely to meet the need, especially in outlying areas of the County. The needs assessment proposed as a part of needle exchange implementation will help define demand for additional needle exchange services.

Funding Needle Exchange. Cost remains a significant barrier in implementing needle exchange in Los Angeles County. Currently the City of Los Angeles provides approximately $500,000 to support needle exchange programs through two consortia. Due to restrictions, state and federal funds cannot be used to purchase syringes. In addition the City of Los Angeles does not provide funding for syringes. Current needle exchange programs rely on limited private sources to fund aspects of their programs for which City funding is unavailable.

Ideally a County certification process would include sufficient funding to support needle exchange programs to expand to areas of the County where syringes are difficult to access. Due to the current fiscal conditions, DHS is unable to provide funding for needle exchange programs. In addition, in previous discussions with County Counsel potential liability issues were raised as a barrier to providing funding for syringes to certified needle exchange programs. Should the Board of Supervisors wish to consider funding for needle exchange programs, and County Counsel agrees that this would not significantly increase liability, DHS has identified syringes[26] and syringe disposal as some of the highest priorities for additional funding.

In order to expand needle exchange to other areas of the County funding will be needed to provide funding for the staffing, supplies and other resources needed to implement needle exchange effectively. Previously, during Phases II and III of the implementation plan, DHS planned to work with Needle Exchange Implementation Workgroup to seek funding to expand needle exchange through grant or foundation sources. If the Board wishes to expand needle exchange beyond the existing city funded programs, DHS recommends that the workgroup includes exploring funding for expansion as a part of its charge.

References and Notes

[1] Acute Communicable Disease Control, Los Angeles County Department of Health Services. *Annual Morbidity Report 2002.*

[2] Des Jarlais, D., Marmor, M., Paone, D, Titus, S., Shi, Q., Perlis, T., Jose, B., Friedman, S., HIV Incidence Among Injecting Drug Users in New York City Syringe-Exchange Programmes, *Lancet,* 1996;348

[3] Paone, D., Des Jarlais, D., Gangloff, R., Milliken, J. and Friedman, S., Syringe Exchange: HIV Prevention, Key Findings, and Future Directions, *International Journal of the Addictions,* 1995, Volume 30.

[4] Brooner, R., Kidorf, M., King, V., Bielenson, P., Svikis, D., Vlahov, D., A drug Abuse Treatment Success among Needle Exchange Participants. *Public Health Reports*, 1998, 113;Supplement 1: 130-139.

[5] Hagan, H., McGough, J.P., Hanne, T., Hopkins S., Duchin J., Alexander. EA. Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle Exchange Participation in Seattle Drug Injectors. *Journal of Substance Abuse Treatment,* Volume 19, Issue 3, October 2000, Pages 247-252

[6] Vlahov, D., Junge, B., Brookmeyer, R., Cohn, S., Riley, E., Armenian, H., and Beilenson, P., Reductions in High-Risk Drug Use Behaviors Among Participants in the Baltimore Needle Exchange Program, *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,* Volume 16, Number 5, 1997

[7] Vlahov, D. and Junge B., The Role of Needle Exchange Programs in HIV Prevention, *Public Health Reports,* June 1998, Supplement

[8] Centers for Disease Control and Prevention, *The Public Health Impact of Needle Exchange Program in the United States and Abroad: Summary, Conclusions and Recommendations. October 1993.*

[9] Lurie P and Reingold AL. 1993. *The public health impact of needle exchange programs in the United States and abroad.* University of California and the Centers for Disease Control and Prevention.

[10] Normand J, Vlahov D and Moses LE. 1995. *Preventing HIV transmission: The role of sterile needles and bleach.* Washington, DC: National Academy Press.

[11] Holtgrave DR, Pinkerton SD, Jones TS, Lurie P, Vlahov D, 1998. Cost and cost-effectiveness of increasing access to sterile syringes and needles as an HIV prevention intervention in the United States. . *J Acquired Immune Defic Syndr Hum Retrovirol* 18 (Suppl 1):S133-138.

[12] Centers for Disease Control and Prevention. 2000. Soft tissue infections among injection drug users — San Francisco, California, 1955-1999. *Morbidity and Mortality Weekly Report* (in press).

[13] Longshore D, Hser Y, Anglin MD. 1995. *Report on Estimated Prevalence of Injection Drug Users in Los Angeles County*. University of California Drug Abuse Research Center

[14] *It is difficult to develop an estimate of the potential scope of need County-wide due to limited data regarding the actual number of injection drug users in the County. In the estimates provided below, both the number of IDUs enrolled in drug treatment and in those in existing needle exchange programs have been subtracted from the total number of IDUs in Los Angeles County. Using an estimate of 155,000 IDUs in Los Angeles County (the midpoint between the upper and lower estimated number of IDUs) and subtracting the number of IDUs in publicly funded drug treatment programs (11,351) and enrolled in the five City-funded and the two non-City-funded needle exchange programs (5,726) results in an estimate of 137,923 IDUs.*

Los Angeles County Injection Drug Users	
Total Estimated IDUs	155,000
IDUs in Treatment	11,351
IDUs Participating in Needle Exchange	5,726
Estimated IDUs Not in Treatment or Using Needle Exchanges	***137,923***

The estimated number of at-risk IDUs is then multiplied by the proportion of IDUs that share needles, resulting in an estimate of the number of IDUs at-risk due to needle sharing. The resulting estimate assumes that IDUs who share needles do not have access to sterile injection equipment. Recent studies with Los Angeles County IDUs indicate that 45 percent share injection equipment[14]. Using this proportion, an estimated 68,962 IDUs use shared injection equipment countywide[14]. Based on these estimates, needle exchange services are provided to less than ten percent of the IDUs at risk due to needle sharing.

[15] Longshore D, Annon J, Anglin MD. 1998. Long-term trends in self-reported HIV risk behavior: injection drug users in Los Angeles, 1987 through 1995. *J Acquir Immune Defic Syndr Hum Retrovirol.* 18:64-72.

[16] Bluthenthal RN, Kral AH, Erringer EA, Edlin BR. 1999. Drug paraphernalia laws and injection-related infectious disease among drug injectors. Journal of Drug Issues 29(1):1-16.

[17] Grund JPC, Heckathorn DD, Broadhead RS, Anthony DL. 1995. In Eastern Connecticut, IDUs purchase syringes from pharmacies but don't carry syringes. [letter]. . *J Acquired Immune Defic Syndr Hum Retrovirol* 10:104-105.

[18] Rich JD, Dickinson BP, Liu KL, Case P, Jesdale B, Ingegneri RM, Nolan PA, 1998. Strict syringe laws in Rhode Island are associated with high rates of reusing syringes and HIV risks among injection drug users. [letter]. . *J Acquired Immune Defic Syndr Hum Retrovirol* 18 (Suppl 1): S140-S141.

[19] Gostin LO. 1998. The legal environment impeding access to sterile syringes and needles: The conflict between law enforcement and public health. . *J Acquired Immune Defic Syndr Hum Retrovirol* 8 (Suppl 1):S60-S70.

[20] Centers for Disease Control and Prevention. 2000 above.

[21] Gostin LO, Lazzarini Z, Jones TS, Flaherty K. 1997. Prevention of HIV/AIDS and other blood-borne diseases among injection drug users. *Journal of the American Medical Association* 277(1):53-62.

[22] Valleroy LA, Weinstein B, Jones TS, Groseclose SL, Rolfs RT and Kassler WJ. 1995. Impact of increased legal access to needles and syringes on community pharmacies' needle and syringe sales – Connecticut, 1992-1993. . *J Acquired Immune Defic Syndr Hum Retrovirol* 10(1):73-81.

[23]Groseclose SL, Weinstein B, Jones TS, Valleroy LA, Fehrs LJ, Kassler WJ. 1995. Impact of increased legal access to needles and syringes on practices of injecting-drug users and police officers -- Connecticut, 1992-1993. . *J Acquired Immune Defic Syndr Hum Retrovirol* 10:82-89.

[24] Shah NG, Celentano DD, Vlahov D, Stambolis V, Johnson L, Nelson KE, Strathdee SA. 2000. Correlates of enrollment in methadone maintenance treatment programs differ by HIV-serostatus. *AIDS* 14(13):2035-2043.

[25] Strathdee SA, Celentano DD, Shah N, Lyles C, Stambolis VA, Macalino G, Nelson K, Vlahov D. 1999. Needle-exchange attendance and health care utilization promote entry into detoxification. *Journal of Urban Health* 76(4):448-460.

[26] It is estimated that needle exchange programs operating in Los Angeles County exchange approximately 1 million syringes annually. At an estimated cost of $0.10 per syringe, $100,000 would provide enough syringes for the existing exchange programs.

Appendix One

MINUTES OF THE BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES, STATE OF CALIFORNIA

Violet Varona-Lukens, Executive Officer-
Clerk of the Board of Supervisors
383 Kenneth Hahn Hall of Administration
Los Angeles, California 90012

Director of Health Services

At its meeting held August 29, 2000, the Board took the following action:

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Supervisor Yaroslavsky made the following statement:

"During the 1999 legislative session, Governor Davis signed AB 136, which permits the operation of needle exchange programs in counties and cities as a public health measure to prevent the spread of HIV/AIDS and other communicable diseases. The legislation protects counties, cities and their agents who operate such programs, from criminal liability under State law relating to the possession and distribution of needles and syringes.

"This protection is contingent upon a declaration of local emergency due to the existence of a critical local public health crisis. Based on an opinion prepared by County Counsel, this would not necessitate an emergency declaration under the California Emergency Services Act. AB 136 provides the legal framework for the development of a local needle exchange program.

"There is a public health crisis in Los Angeles County which justifies the development of a needle exchange program. The spread of communicable diseases, including HIV/AIDS and hepatitis, is associated with the sharing of common needles among multiple users of illicit drugs. Approximately 10% of injection drug users in Los Angeles County are infected with HIV, and a much larger percentage is infected with hepatitis.

(Continued on Page 2)

"Research has documented that needle exchange programs are effective weapons in the war against HIV/AIDS. In 1998, Donna Shalala, Secretary of Health and Human Services, issued a statement that 'meticulous scientific review has now proven that needle exchange programs can reduce the transmission of HIV and save lives without losing ground in the battle against illicit drugs.' The Secretary's

statement also emphasized that successful needle exchange programs are operated 'on a replacement basis only.' A properly managed needle exchange program will permit the disposal of dirty, used needles and their exchange for clean, new ones, thus reducing the number of infectious needles in circulation. This will also minimize the hazard of accidental injury and infections from dirty needles discarded in public places. Needle exchange programs can also serve as a bridge to drug treatment and reduction of drug abuse.

"Given the public health crisis associated with the spread of communicable disease through intravenous drug use, the Board should make the appropriate declaration under AB 136 to permit the certification and, thereafter, the operation of needle exchange programs in Los Angeles County. The Board should also initiate the development of guidelines for such needle exchange programs. Such programs must be developed and operated according to appropriate standards, including stringent controls to protect the public from any potential risk associated with the distribution of needles. Standards and procedures should be developed in the context of our goals of reducing the spread of communicable disease, treating drug abuse and reducing the illegal use of drugs. The standards should include appropriate requirements for community notification and acceptance. It is imperative that such procedures be developed before the first needle is exchanged through any County sanctioned needle exchange program."

Dr. Jonathan Fielding, Director, Public Health, Department of Health Services, Mimi West, Narcotics and Dangerous Drugs Commission, Ferd Eggan, Los Angeles City Aids Coordinator, Chris Wade, California Association of Alcohol and Drug Program Executives, Terry Hair, Clean Needles Now, Mark Casanova, Homeless Health Care, Los Angeles, Nettie De Augustine, Los Angeles County Commission on HIV Services, and other interested persons addressed the Board.

(Continued on Page 3)

Syn. 94 (Continued)

After discussion, on motion of Supervisor Yaroslavsky, seconded by Supervisor Molina, duly carried by the following vote: Ayes: Supervisors Burke, Yaroslavsky and Molina; Noes: Supervisors Knabe and Antonovich, the Board took the following actions:

1. Declared the existence of a critical local public health crisis under AB 136 (Mazzoni), which protects counties, cities and their agents from criminal liability for the operation of needle exchange programs as a public health measure to prevent the spread of HIV/AIDS and other communicable diseases;

2. Instructed the Director of Health Services to report to the Board within 90 days with a plan for the implementation of a needle exchange program within the County, on a replacement basis only, with plan to include criteria related to the certification of needle exchange operators in Los Angeles County, policies and procedures related to the operation and monitoring of needle exchange programs,

including the role of needle exchange programs as a bridge to drug treatment, and appropriate requirements for community notification and acceptance; and

3. Instructed the Director of Health Services in conjunction with development of this plan, to seek the advice of the Sheriff, the Narcotics and Dangerous Drugs Commission, the Commission on HIV Health Services, the Public Health Commission, the Second District HIV/AIDS Coalition, the Prevention Planning Committee, the Los Angeles City AIDS Coordinator and other appropriate groups.

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Copies distributed:
Each Supervisor

Sheriff

Chief Administrative Officer
County Counsel

Chair, Narcotics and Dangerous Drugs Commission

Co-Chair, Commission on HIV Health Services
Chair, Public Health Commission
Co-Chair, Second District HIV/AIDS Coalition

Co-Chair, Prevention Planning Committee
Los Angeles City Aids Coordinator

Los Angeles County Department of Health Services

Needle Exchange Certification Program

Implementation Plan

April 6, 2001

Executive Summary

Background

Needle Exchange Programs (NEPs) were started in the 1980s largely as a public health response to the HIV epidemic and, later, Hepatitis B and C. In Los Angeles County, there have been 6,169 cases of injection drug associated advanced HIV disease (AIDS). NEPs, by providing people with access to clean syringes, help prevent further transmission of HIV and other blood-borne pathogens. In addition, NEPs serve as an important venue for providing injection drug users with referrals to medical and social services, including access to drug treatment.

California law prohibits the furnishing, possession or use of hypodermic needles without a prescription. Assembly Bill 136 (AB 136), Clean Needle and Syringe Exchange Projects, was approved by Governor Gray Davis October 7, 1999. It amended Section 11364.7 of the California Health and Safety Code to exempt from criminal prosecution public entities and their agents and employees who distribute hypodermic needles or syringes to participants in clean needle and needle exchange projects that are authorized by the public entity pursuant to a declaration of local emergency due to a critical public health crisis.

On August 29, 2000, the Los Angeles County Board of Supervisors (Board) instructed the Department of Health Services (DHS) to develop a plan to certify needle exchange programs in Los Angeles County on a replacement basis. In exchange for following the County's needle exchange guidelines, certified agencies would receive protection from criminal prosecution, as indicated by AB 136. This action was taken in recognition of the public health crisis related to the transmission of HIV and hepatitis due to needle sharing among injection drug users and the considerable literature indicating the efficacy of needle exchange as an effective risk reduction intervention.

Implementation Plan Development

Per the Board's instructions, the Needle Exchange Implementation Work Group was convened in September 2000 to develop a plan to certify needle exchange programs in Los Angeles County. The work group included staff from several DHS Public Health programs and representatives from the Sheriff's Department, the HIV Health Services and Narcotics and Dangerous Drug Commissions, the Second District Coalition and HIV Prevention Planning Committee were core work group members. The Los Angeles City AIDS Coordinator and representatives from the Los Angeles Needle Exchange Consortia, RAND and the Long Beach Health Department provided additional input and expertise.

In preparation for developing the needle exchange implementation plan, the work group reviewed existing needle exchange programs in Los Angeles County and other jurisdictions, reviewed data related to the potential demand for needle exchange services in Los Angeles County and conducted a focus group with current needle exchange providers to assess gaps in services for injecting drug users in the County. Public health literature regarding effective needle exchange programs was reviewed to ensure that the plan developed would follow best practices as closely as possible.

The resulting plan emphasizes collaboration between public health, law enforcement and the community in promoting the health and safety of the population of Los Angeles County by supporting programs designed to prevent HIV/AIDS and other injection-related infectious diseases and drug dependency.

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Implementing Needle Exchange Certification

The plan developed by the work group establishes a three-phase implementation process for certifying needle exchange programs in Los Angeles County. During Phase I, the County would certify existing needle exchange programs provided they agreed to follow the County's needle exchange guidelines, which specify that needles will be available to clients enrolled in programs on a one-to-one replacement basis. Seven agencies currently conduct needle exchange in the City of Los Angeles, five as a part of a City funded HIV risk and harm reduction consortium. The seven programs operate needle exchanges at 19 sites. Certified programs would work with resource specialists from the County Alcohol and Drug Program's Community Assessment Services Centers to ensure that needle exchange clients who request placement in drug treatment programs and other services would be placed as quickly as possible to ensure the best possible outcomes.

During Phase II, needs assessments would be conducted to identify gaps in needle exchange services. Based on available funding, a Request for Proposals would be issued to expand services into additional high-need areas. In Phase III, new certified needle exchanges would be opened in identified areas. The scope of the expansion would depend in part on available funding.

Once the needle exchange implementation plan has received Board approval, Phase I of the implementation process will begin. As a part of implementation, needle exchange programs will be monitored to ensure compliance with County guidelines. Data collected at the sites will be reviewed to ensure that needle exchange clients are being referred into treatment and other services and to help determine where new exchange sites are needed. Certified needle exchange programs will reduce barriers to service and provide injection drug users with a venue for accessing clean syringes and referrals and linkage to much needed medical, drug treatment and social services.

Section I: Background

HIV presents a serious threat to Los Angeles County injection drug users (IDUs) and their sexual and needle sharing partners. As of September 30, 2000, there were 6,169 persons living with injection drug associated advanced HIV disease (AIDS) in Los Angeles County. Sixty-one of these cases are children under the age of 13 exposed prenatally[1]. This represents 13.4 percent of all adult AIDS cases, and 26.3 percent of all pediatric cases. A significant body of research indicates that needle exchange, when combined with a comprehensive continuum of HIV prevention, HIV early intervention and drug treatment programs, can be an effective method of preventing transmission of HIV among IDUs.

California is one of only 10 states that criminalize the furnishing, possession or use of hypodermic needles without a prescription; four states waived their prohibitions in the past 10 years to allow for HIV prevention needle exchange projects. Under current California law, only pharmacists and physicians may furnish hypodermic needles without prescription or permit for use in injecting insulin and adrenaline.

Assembly Bill 136 (Clean Needle and Syringe Exchange Projects) was approved by Governor Davis on October 7, 1999. The legislation amended Section 11364.7 of the California Health and Safety Code to exempt from criminal prosecution public entities and their agents and employees who distribute hypodermic needles or syringes to participants in clean needle and syringe exchange projects authorized by the public entity pursuant to a declaration of local emergency due to the existence of a critical local public health crisis.

On August 29, 2000 the Los Angeles County Board of Supervisors (Board) instructed the Department of Health Services (DHS) to develop a plan to implement certification of needle exchange programs within the County. This action was taken in recognition of the public health crisis related to needle sharing and its relation to the transmission of infectious diseases including HIV and hepatitis B and C and in recognition of the considerable literature indicating the efficacy of needle exchange as an effective risk reduction intervention.

This document presents a three-phase implementation plan that allows for certification of existing needle exchange programs (NEPs), additional needs assessment, gap analysis and resource identification, and a comprehensive planning phase including service expansion.

Needle Exchange in Los Angeles County

The Centers for Disease Control and Prevention (CDC) issued a report regarding the efficacy of needle exchange as an HIV prevention intervention in October 1993[2]. On July 14, 1994, the Los Angeles County HIV Health Services Planning Council voted to request a declaration of a state of emergency in the City and County of Los Angeles to allow needle exchange as a public health measure. DHS provided the Board with a recommendation on needle exchange indicating that needle exchange was an appropriate public health measure on September 22, 1994. That same month, Mayor Riordan declared a state of emergency in the City of Los Angeles. Subsequently, the city granted a total of $310,000 to three private groups to conduct needle exchange and other AIDS prevention activities targeting IDUs. These grants prohibited the use of public funds to purchase needles and syringes.

On October 12, 1994, County Counsel provided the Board with a preliminary analysis of the legality of needle exchange programs and later requested an opinion from the State Attorney

General. On November 4, 1994 DHS, in response to a Board request, recommended three potential actions regarding needle exchange: (1) continue support of legislation to establish pilot needle exchange programs; (2) instruct DHS to take any lawful action through departmental programs and in conjunction with HIV prevention contractors to achieve the public health purpose of HIV prevention among IDUs by referral to comprehensive health and drug treatment programs; and (3) instruct DHS and the County's legislative advocates to seek funding to assure that drug treatment is available to all who seek treatment.

The Department's 1994 recommendation included the following caveats regarding needle exchange program components:

- Exchange rather than distribution: NEPs should provide for an *exchange* of injection equipment, rather than a unilateral distribution in order to increase the likelihood that the program would have the added benefit of reducing the number of discarded syringes found in public sites, thereby reducing the danger of accidental infection of others.

- Community acceptance: Local support was viewed as an essential factor in communities where exchange programs would be sited.

- Linkages with substance abuse treatment and other outreach and prevention programs: Needle exchange programs should work cooperatively with existing outreach programs to maximize the provision of HIV prevention education to NEP participants.

- Needle exchange as a part of a continuum: NEPs should not be viewed as free standing distribution operations, but rather as part of a larger continuum of services including distribution of bleach and condoms, targeted sexual risk reduction and behavior change instruction, referrals to HIV testing and early intervention, STD screening, substance abuse treatment, and other related medical, psychosocial, and social programs.

On March 24, 1995 County Counsel issued an opinion to DHS regarding County contracted HIV prevention programs and services and needle exchange programs. Based on the opinion of State Attorney General, County Counsel determined that needle exchange programs remained unlawful due to state prohibitions regarding the distribution of hypodermic needles without a prescription. However, it was determined that County funded programs could provide HIV prevention, testing and referral services to individuals at needle exchange sites as long as those services were separate from the needle exchange.

Needle Exchange Programs in Los Angeles County

The first needle exchange in Los Angeles started in 1992 in Hollywood by a group of ACT UP activists in response to the AIDS epidemic. That program, initially run as an underground exchange, became Harm Reduction Central, now known as Clean Needles Now. A second underground exchange was started in 1993 in South Central Los Angeles by an individual affiliated with Minority AIDS Project. A third exchange was started in 1994 in the San Fernando Valley by Tarzana Treatment Center.

Following Mayor Riordan's 1994 declaration of a state of emergency in the City of Los Angeles, the City began to grant money to agencies to conduct harm reduction activities among IDUs. Currently, five agencies are funded by the City to provide harm reduction services. The City grants pay for some harm reduction staff and supplies, but agencies are prohibited to use this funding for purchase of needles and syringes. Four of the five City-funded agencies also have contracts with the County of Los Angeles to provide HIV risk reduction services. The agencies currently funded by the City are:

- Bienestar Human Services, which operates needle exchange programs at four sites in the East Los Angeles area and contracts with DHS for a variety of HIV risk reduction, case management, mental health and self-help services.

- Clean Needles Now (CNN), which operates exchanges at five sites and does not contract with DHS for preventive services.

- Common Ground, which operates a needle exchange program at one site in West Los Angeles and contracts with DHS for HIV risk reduction services for homeless persons.

- Minority AIDS Project (MAP), which operates needle exchange programs at three sites in South Los Angeles and contracts with DHS for a variety of HIV risk reduction and case management services.

- Tarzana Treatment Center, which operates needle exchange programs at four sites in the San Fernando Valley area and contracts with DHS for a variety of HIV risk reduction, outpatient medical, case management, mental health, self-help and drug treatment services. Tarzana Treatment Center is the lead agency for the five NEPs.

These five City-funded agencies compose the Needle Exchange Consortium. All use standardized data collection forms for enrollment of individual clients and for every subsequent encounter with each client. Data is transferred to Children's Hospital Los Angeles' Division of Adolescent Medicine, which is responsible for evaluation activities.

The City also funds a consortium of providers providing wrap-around services in the downtown area of Los Angeles. The three-agency consortium includes Clean Needles Now (CNN), Homeless Health Care Los Angeles and La Clinica Oscar Romero. CNN provides needle exchange services. La Clinica Oscar Romero provides primary health care including HIV testing and dental assessments and referral. Homeless Health Care Los Angeles provides outreach, case management, drug, alcohol and mental health assessments and referral to drug treatment, primary care and needle exchange services.

Two additional agencies currently provide needle exchange services in the City of Los Angeles. Both are privately funded and are not part of the City's Needle Exchange Consortium. They collect data on their own in-house data forms. These agencies are:

- Asian-American Drug Abuse Program (AADAP), which operates needle exchange in South Central Los Angeles. Outreach workers exchange needles with clients on the street as part of their community outreach. There are no fixed sites.

- South Los Angeles Community AIDS Project (SLACAP), in affiliation with Watts Health Foundation, which operates a needle exchange program at three street-based sites in South Los Angeles.

Needle exchange and referral services for IDUs are available at different sites around the City of Los Angeles, some store-front and some street-based, six days a week. In addition to needles and syringes, all sites provide a variety of harm reduction supplies, including alcohol wipes and condoms. All sites provide referrals to drug treatment for clients, and most provide referrals to other related services.

Research suggests that needle exchange programs have had a significant impact on IDU risk behaviors in Los Angeles. Research conducted in Los Angeles County as a part of a multi-site

CDC study revealed that among Los Angeles County IDUs, having used a sterile syringe at last injection was significantly associated with use of needle exchange programs[3]. Trends in self reported HIV risk behaviors among IDUs between 1987 and 1995 showed a high prevalence of needle sharing until 1994, followed by a sharp decrease in 1995 concurrent with the advent of City-funded needle exchange programs. [4]

Implementing Needle Exchange Certification in Los Angeles County

Based on the Board's August 29, 2000 direction the Needle Exchange Implementation Working Group was convened to develop a plan for certifying needle exchange programs in the County. Programs certified by the County would agree to conduct their needle exchanges using a County sanctioned protocol and they would receive limited protection from criminal liability related to the existing paraphernalia laws.

The workgroup consisted of members from DHS (Public Health Executive Office, Office of AIDS Programs and Policy, Alcohol and Drug Program Administration, Health Assessment and Epidemiology, HIV Epidemiology, Community Health Services, Communicable Disease Control, Sexually Transmitted Disease Control Program, and Public Health Communications). Representatives from the HIV Health Services and Narcotics and Dangerous Drug Commissions, the Second District Coalition, and HIV Prevention Planning Committee were core working group members. Additional input and expertise was sought from the Sheriff's Department, the LA City AIDS Coordinator, the Los Angeles Needle Exchange Consortium, RAND and the Cities of Pasadena and Long Beach Health Departments (see Appendix Five). The goal of the workgroup was to develop an implementation plan for a needle exchange certification program in Los Angeles County.

Workgroup members formed several small committees to focus on specific areas of implementation plan development. Six committees were formed focusing on: (1) Certification; (2) Communications & Relationships; (3) Services; (4) Monitoring and Administration; (5) Evaluation; and (6) Training. The subcommittees were responsible for researching each area, and making recommendations to the workgroup and providing input into applicable sections of the implementation plan. The workgroup met at least twice monthly with additional committee meetings and conference calls as needed.

Best Practices and Lessons from Other Jurisdictions

The workgroup convened in order to make recommendations about needle exchange certification and implementation in Los Angeles County based on sound public health principles, best practice, lessons from other jurisdictions and evidence of effectiveness. As background for the development of the needle exchange certification program workgroup members: (1) reviewed the public health literature regarding needle exchange; (2) interviewed coordinators from current needle exchange programs operating in California; (3) conducted a focus group with coordinators from agencies currently providing needle exchange in Los Angeles; and (4) reviewed data from a client survey coordinated by the Los Angeles Needle Exchange Consortium to determine gaps in services. The workgroup's review of the literature revealed principles and practices on which effective needle exchange programs should be based. These are outlined in the following discussion.

Needle exchange programs began operating in the United States in the late 1980s as a public health response to the HIV epidemic. Injection drug users who shared needles were becoming infected with HIV and then transmitting the virus to their injecting and sexual partners and to

their children parenterally. Concerned public health officials and AIDS activists began to promote needle exchange as a method for preventing the spread of HIV, as well as other diseases transmitted through contact with infected blood (e.g. hepatitis B and C).

A preponderance of the literature has shown that needle exchange programs have been effective in reducing transmission risks among IDUs[5,6]. Needle exchange not only makes good public health sense, it is also cost effective. A recent analysis indicated that up to 12,350 persons would become infected with HIV in the United States for each year that IDUs do not have increased access to needle exchange programs, leading to an estimated $1.3 billion in future medical costs for these persons[7]. Further, according to recent research, an estimated 7 percent of inpatient admissions to San Francisco General Hospital were for soft tissue infections related to injection drug use, including abscesses, resulting in steep costs for hospitalization as well as harm to the patient[8]. Such infections could be reduced significantly if IDUs had better access to medical care, which needle exchange can facilitate through wrap-around services.

A New Syringe for Every Injection

When needle exchange programs began, the primary focus was on educating IDUs about the public health risks associated with sharing needles and providing them with a venue for obtaining sterile needles to reduce needle sharing. Consistent with medical standards, the CDC recommended that IDUs use a sterile needle for *every* injection. This not only prevents transmission of infection between individuals but also reduces the likelihood of infection due to re-use of needles.

IDUs share needles because of lack of access to sterile needles and the fear of arrest for carrying needles[9,10,11]. Some states, including California, have prescription laws, which prevent IDUs from purchasing needles legally at pharmacies without a prescription. Paraphernalia laws exist in most states, including California, preventing IDUs from carrying syringes. Needle exchange has become an important public health service because it facilitates IDUs' access to sterile needles. In addition, it provides linkages to other services for IDUs, including drug treatment and helps move IDUs through a continuum of behavior change from injecting drugs to becoming drug-free.

Research indicates that the availability of needle exchange in a community does not encourage non-users to begin injecting drugs, nor does it increase drug use among IDUs[12]. Minimum client age limits are relatively rare at needle exchanges in the United States[3]. Many IDUs under age 21 using needle exchange services are "runaway" or "throwaway" youth living on the streets. Patterns of needle sharing are similar regardless of age. If unable to obtain sterile syringes through needle exchange programs, IDUs, regardless of age, are more likely to use dirty syringes thereby increasing the risk of HIV and hepatitis transmission.

Access to Risk Reduction Supplies

Initially, needle exchange programs focused on providing IDUs with sterile needles. Consistent with the goal of reducing transmission risk, exchange programs began to offer IDUs other supplies associated with injecting drug use, including cookers and cottons (to filter impurities and reduce the risk of infection), to reduce the public health risks associated with sharing these supplies. Currently, most needle exchange programs, including all of those operating in Los Angeles, provide IDUs with sterile harm reduction supplies.

In Los Angeles, both City and privately funded needle exchange programs provide clients with harm reduction tools such as bleach for cleaning needles, alcohol swabs and antibiotic cream for preventing abscesses and other infections, condoms to prevent spread of STDs and HIV. All

exchanges also provide clients with appropriate public health literature. Most needle exchanges also now offer wound care information and supplies to help prevent medical problems associated with injecting drugs such as abscesses and endocarditis.

Access to Drug Treatment and Other Wrap-Around Services

IDUs are a hidden population and difficult to reach with most services. IDUs who use needle exchange generally have a higher level of baseline severity of drug use than those who do not use needle exchange[13]. Needle exchange meets IDUs "where they are" both geographically and in terms of their drug use and readiness to seek treatment, and provides a valued service. By building trust with the IDUs they serve and establishing strong linkages into treatment and other referral sources, needle exchange providers are able to facilitate entry into treatment and other harm reduction services.

Needle exchange programs have served as a conduit into treatment for IDUs[6,14,15]. However, it is important that entry into treatment take place quickly once an IDU requests a referral. There is an increased failure rate associated with delayed entrance into drug treatment among IDUs utilizing needle exchange services. According to one study in New Haven[5], IDUs who had to wait more than three weeks to be placed in treatment were more likely to fail to complete that treatment. Los Angeles needle exchange providers stressed the importance to their clientele of assuring that they are able to access drug treatment as soon as it is requested.

Needle exchange also can provide referrals to other types of services IDUs do not otherwise access, such as medical care. This is particularly important in light of evidence indicating the severity of illness and high costs incurred when IDUs do not access these services when the need first arises[16].

Appropriate Types of Exchange Venues

Needle exchange sites may be fixed or mobile. While there are many types of sites, most are either street-based or based in agencies that provide related services for IDUs. In Los Angeles, the majority of current exchanges are street-based, i.e. they operate out of the backs of vans or at card tables set up on the streets in fixed locations on specific days and times each week.

Store-front sites appear to provide the greatest capacity for making strong referrals into wrap-around services such as drug treatment and medical care. However, store-fronts have higher operational costs. In addition, some IDUs are thought to feel more comfortable with mobile sites, which are easier to get into and out of quickly. Agencies such as San Francisco AIDS Foundation' s HIV Prevention Project, the largest needle exchange in the United States, operates both types of sites in an effort to reach as many IDUs as possible.

Mobile vans offer an opportunity to provide essential services such as drug treatment referrals, HIV testing and wound care in a confidential manner at street-based venues. In addition, mobile units provide IDUs with equal access to services regardless of the type of exchange provided in their service area.

Relationship with Law Enforcement

Historically public health and law enforcement have adopted different and contradictory approaches in dealing with injecting drug users. While public health officials advocate providing IDUs with sterile needles as a risk reduction activity, law enforcement officials are charged with enforcing paraphernalia laws. In order for NEPs to provide the most effective harm reduction services it is essential to have the support of law enforcement. A local jurisdiction's declaration

of a public health crisis should prevent IDUs from having needle exchange syringes confiscated, but this requires communication and cooperation between public health and law enforcement communities. As Gostin et al. (1997) points out, "Ultimately, both law enforcement and public health seek the same end – to promote the health and safety of the population through a comprehensive program designed to prevent HIV/AIDS and drug dependency."[17]

In jurisdictions that prohibit the possession of injection equipment without a prescription, IDUs sometimes are arrested for carrying syringes. Many IDUs report that they are afraid to carry syringes for fear of arrest. This leads to increased public health risk through needle sharing and improper disposal. Some argue that reform in drug paraphernalia laws that prohibit the *illicit* distribution of drug injection equipment is essential to ensure consistency with public health objectives[8]. Following a partial repeal of paraphernalia laws in Connecticut, syringe sharing decreased[18]. Further, the needle-stick injury rates among Hartford police officers also were lower after the new laws[19].

In summary, best practices from the literature and discussions with needle exchange programs indicate:

- Barriers to access and utilization of needle exchange programs must be minimized for effective interaction with IDUs.
- IDUs must have sufficient syringes to prevent sharing. Exchange programs should take into account loss, confiscation and theft of syringes in their exchange protocols.
- IDUs must have access to risk reduction supplies to minimize the transmission risks associated with sharing or not using these items.
- Needle exchange must be a part of an overall comprehensive plan of HIV prevention as well as referral and linkage to drug treatment, HIV, other STD and TB testing, and other health and social services.
- Timely access to drug treatment and other services must be available to clients when they are ready for them.
- Public health, law enforcement and communities must work together to promote the health and safety of the population by supporting programs designed to prevent HIV/AIDS and other injection-related infectious diseases and drug dependency.

Estimating Need for Needle Exchange Services in Los Angeles County

It is estimated that there are between 120,000 and 190,000 injection drug users in Los Angeles County[20]. In developing this plan, several sources of information regarding IDUs were examined in order to estimate potential demand for needle exchange services including information from County-funded drug treatment programs, AIDS case data and current needle exchange programs.

AIDS Surveillance Data

AIDS data indicate that as of September 2000, 5,561 cumulative reported AIDS cases (13.4 percent) were in injection-related exposure categories (male and female IDUs, and men who have sex with men (MSM)/IDUs). In 1999 there were 162 newly diagnosed AIDS cases among injection drug users[21]. AIDS remains an inadequate proxy for HIV infection due to the long period between initial infection with HIV and the development of AIDS, variation in HIV testing and medical follow-up, as well as medical advances impacting the rate of progression to AIDS following HIV infection. The implementation of HIV surveillance via unique identifiers, anticipated to begin early in 2001, will provide will provide better information regarding HIV infection.

The County's HIV Epidemiology Program implemented a methodology to estimate the numbers of new HIV infections, and the rate of HIV infection by behavioral risk group [22]. One risk group examined was injection drug users. Based on this methodology an estimated 430 injection drug users in Los Angeles County contract HIV each year.

Injection Drug Users in County-Contracted Drug Treatment Programs

Data from the Department's Alcohol and Drug Program Administration indicated that 11,351 injection drug users enrolled in County-contracted drug treatment programs in fiscal year (FY) 1999-2000. This represents thirty percent of all substance users enrolled in treatment programs (30.3 percent). There was significant variation in the proportion of IDUs enrolled in various treatment modalities. The majority of substance users enrolled in narcotics maintenance programs (94.7 percent) and in narcotics detoxification programs (92.8 percent) were IDUs. Proportions of IDUs in other treatment modalities varied. In comparison, IDUs represented 59.4 percent of substance users in residential detoxification programs and 10.7 percent of all substance users in non-residential treatment programs.

Injection Drug Users in City-Funded Needle Exchange Programs

Currently, over 5,300 persons participate in Los Angeles City-funded needle exchange programs. In FY 1999-2000 alone, 2,378 new clients enrolled in City-funded NEPs. The vast majority of enrollees were male (72 percent). Program participants were ethnically diverse with whites representing 38 percent, African Americans representing 28 percent and Latinos representing 25 percent of exchange participants. Thirty-eight percent of new enrollees reported being homeless at the time they enrolled in the program and another 26 percent reported a history of homelessness. The primary drug of choice of new NEP enrollees was heroin (71 percent). This is consistent with the primary drug of choice of IDUs enrolled in drug treatment programs during the same year (heroin, 77 percent).

Estimating Need for Needle Exchange Services

It is difficult to develop an estimate of the potential scope of need County-wide due to limited data regarding the actual number of injection drug users in the County. In the estimates provided below, both the number of IDUs enrolled in drug treatment and in those in existing needle exchange programs have been subtracted from the total number of IDUs in Los Angeles County. Using an estimate of 155,000 IDUs in Los Angeles County (the midpoint between the upper and lower estimated number of IDUs) and subtracting the number of IDUs in publicly funded drug treatment programs (11,351) and enrolled in the five City-funded and the two non-City-funded needle exchange programs (5,726) results in an estimate of 137,923 IDUs.

Los Angeles County Injection Drug Users	
Total Estimated IDUs	155,000
IDUs in Treatment	11,351
IDUs Participating in Needle Exchange	5,726
Estimated IDUs Not in Treatment or Using Needle Exchanges	***137,923***

The estimated number of at-risk IDUs is then multiplied by the proportion of IDUs that share needles, resulting in an estimate of the number of IDUs at-risk due to needle sharing. The resulting estimate assumes that IDUs who share needles do not have access to sterile injection equipment. Recent studies with Los Angeles County IDUs indicate that 45 percent share injection equipment[23]. Using this proportion, an estimated 68,962 IDUs use shared injection equipment county-wide[a]. Based on these estimates, needle exchange services are provided to less than ten percent of the IDUs at risk due to needle sharing. There are no estimates of local demand for needle exchange services. However, needle exchange programs operating in the City of Los Angeles report increasing utilization of their services with injection drug users coming from all areas of the County including Antelope Valley and rapid population of new exchange sites.

Lack of data prevents the development of reliable estimates of need for needle exchange services in specific geographical areas. There are no SPA-based estimates of total numbers of IDUs to serve as a basis for such estimates. Data on the number of persons in County-funded drug treatment programs in various Service Planning Areas (SPAs) are available; however these data are less reliable for homeless substance users who report the residential treatment program address as their residence. While numbers of new enrollees in City-funded NEPs are available, no SPA-based data are available on the total numbers of persons exchanging syringes through needle exchange programs.

Capacity for and Access to Drug Treatment Services

Los Angeles County currently has 2,533 County-funded drug treatment slots and 1,806 County-contracted drug treatment beds, representing 21 percent of all licensed drug treatment slots, and 18 percent of all licensed drug treatment beds in Los Angeles County. Because most IDUs are unable to afford drug treatment services they tend to rely on the limited number of County funded slots. The numbers of County funded slots are inadequate to meet the growing demand from injection drug and other substance users. The numbers of IDUs entering drug treatment is increasing (from 9,520 enrolled FY 1998-1999 to 10,336 in FY 1999-2000). The dearth of affordable drug treatment services can result in prolonged waits for services.

Data from the California Drug Abuse Treatment Access Report (DATAR) for the first quarter of FY 1999-2000 indicated injection drug users routinely experience delays in entering drug treatment programs. During the six-month period from May through October 1999, 2,486 injection drug users applied for entry into drug treatment programs and were placed on waiting lists. *Based on a review of data over a three-month period, methadone maintenance waiting*

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[a] *The 62,962 estimate may over- or underestimate the actual numbers of IDUs that share needles in Los Angeles County. Underestimation may result from: (1) underestimating the proportion of individuals that share needles; and (2) assuming those in treatment programs and in needle exchange programs no longer share needles. Over-estimation may result from: (1) underestimating the number of people in treatment (probable because data were not available for privately-funded treatment programs); (2) over-estimating the proportion of IDUs that share needles; (3) assuming that needle exchange program participants only exchange for themselves, rather than for other IDUs; and (4) underestimating the number of IDUs that use needle exchange.*

times ranged from 1.0 to 21.8 days over the three-month period (July through September 1999). Outpatient methadone detoxification waits ranged from 1.3 to 13.3 days during the same period. This is of particular concern given of the research indicating a higher failure rate among needle exchange program clients unable to enter drug treatment immediately[24].

In order to facilitate entry into treatment programs, a liaison, housed in the Alcohol and Drug Program Administration, is proposed to work with needle exchange programs to coordinate linkage, follow-up on referrals, and to track and maintain information about movement of IDUs through the continuum of services from needle exchange through drug treatment. This liaison will be funded through existing resources. In addition, the Alcohol and Drug Program Administration currently has Community Assessment Services Centers (CASC) located in each Service Planning Area. A CASC liaison will work directly with needle exchange programs to facilitate linkage of needle exchange clients to drug treatment programs.

Section II: Needle Exchange Certification Program Overview

Program Administration

The needle exchange certification program will be administered by the Executive Office of Public Health and will represent the collaborative efforts of multiple programs within Public Health. Management of the needle exchange certification process will include the following key administration areas:

- Community Liaison: Public Health will work with the needle exchange programs and community stakeholders, ensure community involvement in selection of additional exchange sites and provide sites with technical assistance regarding drug treatment and wrap-around service referrals.

- Needle Exchange Program Development: Public Health will provide oversight in the refinement of needle exchange protocols and the recommendation of sites for additional needle exchange services.

- Monitoring of Needle Exchange Program Compliance: The certification process will provide NEPs with initial technical assistance on program guidance, conduct site visits and review program data to ensure compliance with County needle exchange guidance.

Needle exchange certification program administration will be managed by staff demonstrating a high level of familiarity and expertise in needle exchange programs, substance abuse and social services. A full-time Contract Program Auditor (or equivalent staff) as well as a part-time Administrative Assistant (or equivalent staff) will be responsible for the day-to-day administration of the needle exchange program contracts.

A Needle Exchange Certification Program Coordinator (Staff Analyst level or equivalent) will provide broad programmatic oversight. The program supervisor will also be responsible for serving as a liaison between the DHS and an ongoing needle exchange program advisory group.

Communications and Public Relations

Communicating with the public, programs within DHS, other County departments, stakeholders, law enforcement and other interested parties will be an on going activity, prior to and during implementation. The table in Appendix One outlines the major audiences, the areas of information to be communicated and potential strategies providing information and establishing and maintaining lines of communication regarding the NEP implementation.

The major audiences that must be addressed in implementing needle exchange certification include the general public, communities where needle exchange programs already exist, the law enforcement community, service providers (including drug treatment, HIV, STD, TB), and program partners that will receive clients referred from the exchanges and provide wrap-around services. During the later phases of implementation, communities where new needle exchange sites will be established must also be included in the communication/public relation activities.

- ***General Public:*** The term "needle exchange" is unfamiliar to the general public and may evoke fear and misunderstanding. DHS will implement a public information campaign to

introduce and reinforce the idea that needle exchange is an effective HIV prevention strategy that has the added benefits of reducing the numbers of discarded used needles in public places, as well as to help link IDUs to drug treatment and other needed health and social services.

- ***Communities with Existing Needle Exchange Programs:*** In these communities, existing needle exchange programs will have already made contact with community members. The goal of the communications/public relations strategy will be to update community members, service providers and stakeholders on the certification process and provide additional reinforcement regarding the efficacy of needle exchange.

- ***Law Enforcement Community:*** Communication with the law enforcement community will be essential in assuring smooth operation of needle exchange programs. The communications strategy will need to emphasize the public health benefits of needle exchange programs and evidence demonstrating a reduction in discarded needles and needle-stick injuries to officers. In addition to working directly with the Sheriff's Department and the Los Angeles Police Department to disseminate information, needle exchange programs must work with local substations and city police department to provide education regarding needle exchange to field officers.

- ***Service Providers:*** Strategies such as presentations, distribution of fact sheets and regular updates will be used to discuss the benefit of comprehensive services, build linkages with new programs and service providers and emphasize needle exchange as an effective prevention strategy.

- ***Needle Exchange Program Partners:*** Program partners are those agencies and services that agree to take referrals from the needle exchange programs and provide clients with services such as HIV, STD and TB screening, testing and treatment, drug treatment services and health and social services. In addition to initial presentations to reinforce providers' understanding of the efficacy of needle exchange programs, frequent program updates and information will be required to maintain and strengthen these linkages.

Program Monitoring and Evaluation

Needle exchange programs currently supported by Los Angeles City Office of AIDS collect a comprehensive list of client-level data for process evaluation purposes. The NEP certification program will use a similar data collection format for certified NEPS to minimize disruption to existing programs.

Process Evaluation

Process evaluation data have been collected on all client exchange visits at up to 17 exchange venues sponsored by up City-funded NEPs since 1996. Appendix Two includes samples of the two scantron forms currently used by NEP staff during routine exchange sessions. The "enrollment form" is completed on each new NEP client. The "encounter form" is completed during all subsequent service episodes for continuing clients. Upon completion, these forms are transferred to Children's Hospital, Los Angeles, for simultaneous scanning and entry into a master database. NEPs are instructed to submit these forms on the 15th day of each month. The evaluation team at Children's Hospital assesses individual NEP activities through continuous collection of these forms and quarterly reports are provided to Los Angeles City and NEPs.

Given the acceptability of the forms to both NEPs and the funding agency, we propose adoption of a similar system to satisfy process evaluation needs for Los Angeles County's implementation of Needle Exchange Program Certification. Briefly, the process evaluation efforts to be continued through Los Angeles County's program will consist of regular and complete monitoring of the following client-level data:

- NEP site
- Unique identity code (based on initials, birth date, and gender, e.g., TB21467F)
- Basic demographics (age, race/ethnicity, sex)
- Zip code
- Number of needles exchanged
- Number of people exchanging for
- Date last injected
- Number of years/months injecting
- Primary injection drug
- HIV test acceptance
- Previous known Hepatitis B infection, or previous vaccination for Hepatitis B
- Number of condoms obtained
- Referral to substance use treatment
- Referral to medical treatment
- Referral to mental health services
- Types of educational messages provided

Program Monitoring

In addition to a formal process evaluation to calculate the types of services and numbers of needles exchanged, we propose a program monitoring system to track NEP adherence to certification requirements. The program monitoring activities should include routine reporting of both adverse and positive outcomes. Examples of adverse events may include un-welcomed police involvement/interference or needle stick injuries. Examples of favorable events may include establishment of community or police partnerships.

We propose a program monitoring plan in which certified NEPs are required to submit monthly reports to the Needle Exchange Certification Program Coordinator containing the following information:

- Community education and collaboration efforts (meetings, etc.)
- Referral and linkage arrangements to medical and social service agencies and providers
- Collaboration with OAPP-funded sites to provide HIV testing
- Collaboration with OAPP or other agencies to coordinate HIV case management services
- Number and content of staff trainings
- Completeness of client-level data collection
- Collaboration with law enforcement (meetings, etc.)
- Number of mobile unit visits for health care
- Adverse events (needle stick injuries, etc.)

Generation of Process and Monitoring Data Reports

Los Angeles County's designated Needle Exchange Certification Program Coordinator will be responsible for the timely distribution of all collected process and monitoring data. Quarterly reports will be submitted to the County Board of Supervisors, NEPs, Office of AIDS Programs and Policy, Drug and Alcohol Program, and other interested parties.

Implementation Timeline

The certification program will be implemented in three phases to provide time for more thorough needs assessment, service gap identification, monitoring of existing programs and to secure funding for service expansion.

During Phase I, existing programs will be certified to implement needle exchange on a replacement basis consistent with the County's needle exchange guidelines. Following Board approval of this plan, an application period will be announced for existing programs and certification will be implemented. Discussions are underway to certify programs funded by the City of Los Angeles provided that they agree to follow County guidelines and that regular reporting is established. Because site visits will be a part of this process, three months are allocated to complete certification of City-funded and other existing exchange programs. Once programs are certified, and funding is available, the County will provide needles for the exchange programs as well as assurance of disposal. In exchange, certified NEPs would agree to adhere to the needle exchange guidelines, link clients to needed services through Community Assessment Services Centers and other referrals networks and consistently provide data to the certification program coordinator.

During Phase II, certified needle exchange will begin. Data collected from the certified programs and other sources will be examined to identify needs for additional services, establish linkages with appropriate wrap-around services, and secure funding for potential service expansion. A limited RFP will be developed to seek additional services in identified areas. Based on available funding, the RFP will be implemented and new needle exchange programs or additional sites will be selected. The selection of additional programs and/or sites depends on available funding.

In Phase III, training will commence with certification of additional needle exchange programs. Should funding permit, expanded wrap-around services such as periodic mobile medical services will be implemented. The scope of expansion will depend in part on available funding or the capacity of new sites to support their exchange programs through independent resources. The table below provides preliminary target dates for the three-phase implementation plan.

Needle Exchange Implementation Timeline		
Implementation Phase	***Activity***	***Target Date***
Phase I	Board approval	Month 0.5
	Certification application period	Month 1.5
	Certification process for existing needle exchange programs	Month 3
	Implementation of certified programs and program monitoring (Certified programs start)	Month 3
Phase II *(Note: Phase II assumes no change in funding of the 7 existing NEPs)*	Monitor existing programs	On going
	Progress Reports and Data Summaries	Months 6, 9, 12, 15
	Develop funding options	Months 3-8
	Conduct gap analysis	Month 8
	Complete needs assessment and make recommendations for location of potential wrap-around services	Month 10
	Release RFP for additional services (pending funding)	Month 12
	Complete contract for additional services based on available funding	Month 15
Phase III	Implement newly certified programs	Month 16

CITY OF LOS ANGELES
AIDS Coordinator's Office

DATE: June 17, 2004

TO: Anna Long, Los Angeles County Department of Health Services

FROM: Stephen Simon, City of Los Angeles AIDS Coordinator

SUBJECT: Los Angeles County Needle Exchange Certification Program

Thank you for giving the City of Los Angeles an opportunity to provide input on your Needle Exchange Certification Program. We have shared the current County of Los Angeles "Policies and Procedures" document for Needle Exchange Certification with our needle exchange providers (NEPs) and have the following questions and concerns.

Overall Comments

The following are a few broad themes that emerged when discussing the certification program with providers:

1. Significant Program Changes with No Supportive Funding - The major concern expressed by NEPs was the belief that the County certification process may involve significant changes to the current operations of programs, without any funding to support the changes. Many of these changes are viewed as cost prohibitive and unrealistic for NEPs.

2. Excessive Detail in Required Operation Procedures – Numerous providers commented that the guidelines prescribe operations down to a level of detail that could be problematic since different programs serve a variety of populations at different types of sites. Providers also suggested that there should be a mechanism for waiving some of the requirements on a case-by-case basis.

3. Lack of Partnership – Overall, providers expressed disappointment that the County was not participating in some of the activities they are expecting NEPs to undertake in the process. For instance, they suggested that DHS should be holding informational meetings with stakeholders and setting up agreements with law enforcement and area health officers. They also commented that it would be appropriate for DHS to assist with the Needs Assessments.

4. Space & Staffing – NEPs are concerned some of the rules will require additional staffing and space that they cannot afford. Some of the following examples are described in more detail below:
    - Space for CASC workers
    - Staff time for referral tracking
    - Staff time for additional reporting requirements on meetings, trainings, annual reports, etc.
    - Additional staff to monitor 1-by-1 syringe sorting
    - Space for storing 90 days of supplies

5. More requirements than other County health programs - (Page 8) Providers believe the Needle Exchange Certification process requires many steps that other current DHS funded programs do not require, such as STD training. One agency that is currently funded through County ADPA contracts to work with the same population said they do not require this stringent training curriculum for staff. Providers feel this is an unequal burden on needle exchange programs and disincentive for starting new NEPs.

6. Decertification and Non-Certified Agencies – There is a great deal of concern among providers regarding decertification. Although the policies and procedures outline the steps for corrective action, some agencies are worried that financial difficulties and frequent staff/volunteer turnover may cause them to frequently fall out of compliance with some of the detailed regulations and they will be unable to meet demands for corrective action (such as keeping a 90-day supply of materials on hand). Additionally, agencies fear that decertification for reasons such as these could have more far-reaching consequences, such as damage to agency reputations and loss of protections and other funding sources. Similarly, providers are concerned that agencies that choose not to participate in the certification program due to extensive requirements will be viewed externally as "less legitimate" than agencies that do participate.

Specific Questions/Concerns for Existing Programs/Sites

The following are some more specific questions and concerns regarding the policies and procedures:

1. Individual Sorting of Used Syringes – NEPs believe this is a time consuming and potentially dangerous requirement. Thousands of people pass through Los Angeles exchanges and some of them come in with very large numbers (hundreds) of used syringes, including secondary exchange syringes. Sorting one by one could significantly increase time required per client and result in fewer clients being served during exchange hours. This procedure could also potentially require more staff and increase the chance for injuries when clients are handling each

individual needle, including secondary exchange needles. NEPs have suggested estimation for large numbers of syringes. Note: the governor has also suggested estimation in his proposed amendments to California Assembly Bill 2871 (Berg).

2. Corking, Capping, Plugging, Filtering Syringes (Page 11) NEPs raised concerns that this requirement will result in uncapped syringes being discarded in an unsafe manner, increasing the number of uncapped syringes on the streets. Also, if secondary syringe exchangers are required to cap syringes belonging to someone else they may be handling syringes of others in a dangerous manner.

3. CASC Worker Requirements - (Section 1) What are the CASC worker requirements at exchanges, and will additional CASC funding be allotted by the County so that CASC staff can be available at each site? NEPs believe CASC resource specialists will not be able to devote more than a few hours a week at needle exchange sites. In some areas this staff is already booked for the full workweek (with current assessments and other duties required by CASC funding) and there are seven NEPs, each with multiple exchange sites and times. This also may not be practical at the numerous street sites, where little privacy/space is available.

4. Initial Harm Reduction Kit – Although a one-for-one model of needle exchange is the general operating procedure for NEPs, would it be possible to allow an initial "harm reduction kit" with less than 10 syringes for new participants? This type of kit has also been suggested by the Governor in his proposed amendments to AB 2871.

5. In-house training - (Page 8) Most NEPs are already covering these topics, but are there any requirements on the structure/ length of this training?

6. Required Training by Other Sources - (Page 9) Are these trainings all available in L.A., and will they be provided free of charge? Is "in-depth training on tuberculosis transmission" really practical/necessary? Providers are also concerned about the cost of lost staffing hours incurred by training requirements.

7. Referral Tracking Documentation - (Page 15 and 16) NEPs said that it would be impossible to follow up on all referrals to drug treatment programs. They do not have the staff to track down individual clients. Sometimes tracking works with incentives, but they cannot offer incentives without additional funding.

8. Maintenance of referral manual - (Page 14 and 15) Although NEPs all offer referrals to other services, they find the requirement to create and maintain a "referral manual" burdensome. Some providers pointed out that

this is not required for other types of County funded programs. Is it possible that this is a resource that the County can produce and distribute to NEPs?

9. Supplies for 90 days – NEPs have indicated that this is difficult for 2 reasons. 1) They are often short on funding and have to buy small amounts of supplies at more frequent intervals. 2) They lack adequate storage space.

10. Single file line – Providers have stated that it is not always practical to have clients stand in a single file line. For example, at a street site it sometimes calls unwanted attention to the fact that an exchange is taking place.

11. Data collection – Data generated by Children's Hospital is paid for by the City of Los Angeles and data for any additional programs or sites not sponsored by the City will require additional funding.

Concerns for Future Programs/Sites

1. Community meetings – NEPs believe the requirement for two public meetings is unrealistic and a deterrent to future programs/sites, since no neighborhood is likely to be enthusiastic about a local needle exchange. They suggested that it would be better for NEPs to get community input through other existing community forums, such as the Los Angeles County Prevention Planning Committee (PPC).

2. Site Selection – (Page 4) The definition of an inappropriate site in the policy and procedures document is too broad. For instance, there are few places in Los Angeles that are not near "residential areas or other settings...likely to cause community opposition." One suggested alternative strategy was to look at where outreach efforts are taking place and consider the appropriateness of those areas.